Summit County
Expanding Treatment Services for Older Adults
Akron, Ohio
TI13530

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PROJECT DESCRIPTION

Enhancement or Expansion—Expansion

Program Area Affiliation—Elderly and Families, Reducing Disparities (Hispanic)

Congressional District and Congressperson—Ohio 14; Tom Sawyer

Public Health Region—V

Purpose, Goals, and Objectives—The project proposes to expand specialized treatment services for older adults. The need for such additional services is critical in Summit County. Older adults with substance abuse problems have historically been misdiagnosed and underserved. Although innovative programs that provide high-quality, age-specific services are available in Summit County through the D. Bruce Mansfield Center, treatment capacity is limited by lack of funding. Therefore, the project is requesting funding to increase the substance abuse treatment capacity at this facility. (pages 4, 9, 12)

Target Population—The project targets adults over the age of 60; however, persons over the age of 50 will be accepted if it is determined that the program would be beneficial to the individual seeking treatment. Of the 200 people that the project proposes to serve, it estimates that 50 percent of them will be over 65 years of age. (pages 4, 7, 12)

Geographic Service Area—Summit County is an urban area whose older adult population (age 65+) represented 14.1 percent of the 2000 census according to reports by the U.S. Census Bureau. (pages 4, 7, 12)

Drugs Addressed—Alcohol and prescription drugs, either alone or in combination, are cited by the project as the primary substance abuse concern within the target population. (pages 8, 12)

Theoretical Model—The primary service provider, D. Bruce Mansfield Center ("Mansfield Center"), a division of Mature Services, Inc., is a certified outpatient facility that employs a holistic, multi-disciplinary approach to treatment. Mansfield Center's service delivery model emphasizes reducing the barriers that older adults may face when seeking treatment. Based on traditional outpatient treatment, the model uses the least restrictive environment, but with the addition of an age-appropriate, age-sensitive methodology. In many cases, this involves the clinicians traveling to the client's residence to administer treatment. However, for those who prefer it, the counseling office is always available. The model builds on the Center for Substance Abuse Treatment's (CSAT's) best practice guidelines in treating the older substance abuser (TIP #26, 1998) and, as such, incorporates the principles of promoting a culture of respect for older clients and maintaining flexible service delivery based on a client's individual needs. (pages 10–11)

SERVICE PROVIDER STRUCTURE

Service Organizational Structure—The County of Summit Alcohol, Drug Addiction, and Mental Health Services Board (ADM board), formerly the Summit County Mental Health Board, was established in 1989 as a consequence of the development of the Ohio Department of Alcohol and Drug Addiction Services. The ADM Board is composed of 18 volunteers representing a variety of community perspectives. Ten board members are appointed by the county executive, four by the director of the Ohio

Department of Alcohol and Drug Addiction Services, and four by the Department of Mental Health. The State appointees include consumers, family members, professionals, and local judges. (page 25)

Service Providers—The ADM board has proposed to contract with Mature Services, Inc. (formerly the Senior Workers Action Program) to provide treatment services through its D. Bruce Mansfield Center. Mature Services, Inc. has been providing specialized substance abuse services to older adults for 17 years.

It is a not-for-profit 501(c)(3) multi-service social service agency that serves older adults throughout nine counties of northeastern Ohio. The Mansfield Center is a division of Mature Services, Inc. and is a State-certified outpatient treatment facility. The ADM board funds the Mansfield Center to provide specialized services for older adults, and the two agencies enjoy a long-established working relationship. (pages 4, 7, 10, 14, 26, 28)

Services Provided—The specialized services provided under this grant include assessment, individual and group counseling, case management, and intensive outpatient services. Since transportation can present a barrier to treatment, it will be provided as needed for counseling sessions and case management activities.

Mature Services, Inc. also has a Senior Employment Center that will collaborate with this grant program to assist clients who are seeking employment.

Any services that are not offered by Mature Services, Inc. will be made available through a network of other area health care providers. These services include crisis intervention, HIV/AIDS services, and methadone treatment. In addition, the Area Agency on Aging will offer several specialized services geared toward the older adult, such as access to homemakers and home health aides, congregate and home-delivered meals, friendly visiting, emergency response systems, and elder rights services. (pages 13–14)

Service Setting—This project proposes to provide services in an outpatient clinic. (pages 4, 9)

Number of Persons Served—This project proposes to provide outpatient treatment services to 200 older adults over the 3-year grant period: 50 persons in Year 1 and 75 persons in each of Years 2 and 3. (pages 4, 9)

Desired Project Outputs—The application discusses several desired outputs in terms of in-treatment objectives, such as the number of clients expected to participate in specific types of services, the percentage of clients who improve their living situation within 90 days of admission, and the number of clients that will be retained in treatment. Other desired outputs more directly reflect treatment outcomes, such as the following (pages 9, 18–20):

- Decreased involvement with the criminal justice system
- Reduced physical/mental health impairments and improved overall health and mental functioning
- Improved social functioning (i.e., increase in social contacts and improvement in ability to interact with others)
- Fewer long-term care facility placements
- Increased employment and independence

Consumer Involvement—The application states that meetings have been held with current clients to solicit their input for the expansion of services under this grant. An advisory committee is also being

formed. Recruited members of the committee include older adults representing the target population, professionals in aging, a physician, a home health nurse, and a clergy person. This advisory committee will be an integral part of this project and will be asked to provide input to the program.

In addition, a random selection of 25 percent of the Summit County social and medical service providers will be surveyed annually to ascertain their knowledge of the proposed program and its services. Responses will be tallied and a determination made with regard to the need for outreach services. (pages 13–14, 18)

EVALUATION

Strategy and Design—The primary framework for the evaluation methodology will be CSAT's 1999 Minimum Evaluation Data Set guidelines, supplemented by additional measures/processes deemed optimal for assessing program outcomes. The evaluation plan utilizes various assessments to analyze project impact on five levels, as follows:

- Service delivery unit—Two assessments will be conducted on an annual basis: an on-site evaluation and an empowerment evaluation
- Treatment program—Examines the possible impact of the clinician on treatment outcomes (e.g., background/experience of the clinician, caseload, therapeutic approach)
- Client outcomes—Analyzes treatment program effectiveness through examination of client data and assessments
- Cost-effectiveness—Monitors treatment program costs to gauge cost-effectiveness
- Community impact—Examines client data that have the potential to impact the community at large (e.g., variables such as levels of unemployment, increased social skills within the client population)

In general, data from annual assessments will be compared, with an emphasis on identifying changes that may impact client outcomes. (pages 15–18)

Evaluation Goals/Desired Results—The project categorizes its evaluation goals using the five categories/levels listed above. These goals are as follows:

- Service delivery unit—There are two evaluation goals that correspond to the two assessments described above: (1) the goal of the on-site evaluation is to better understand how characteristics of the program as a whole relate to proposed goals and client outcomes, and (2) the goal of the empowerment evaluation is to provide skills and training that can be carried beyond the completion of this grant, thus ensuring continued program success.
- Treatment program—The evaluation goal is to determine if there are correlations between counselor characteristics and client outcomes.
- Client outcomes—The evaluation goal is to determine if there are correlations between client characteristics and treatment efficacy.
- Cost-effectiveness—The evaluation goal is to determine unit price for each component of the proposed program and to ensure that the project budget is administered accordingly.
- Community impact—The evaluation goal is to determine the effect of the treatment program on the community at large. (pages 15–18)

Evaluation Questions and Variables—The evaluation plan is set up to answer the questions that are

inherent in the five levels of the evaluation design as listed above. Although not explicitly stated in the application, the primary questions can be deduced from evaluation goals as follows (pages 18–20):

- Did client outcomes demonstrate a reduction in the use of alcohol and illicit substances?
- Did client outcomes demonstrate a reduction in physical health problems? Mental health problems?
- Did client outcomes demonstrate improvement in social functioning?
- Did client outcomes demonstrate a reduction in legal problems/involvement with the criminal justice system?
- Did all clients receive case management services?
- What was the level of client participation and duration of treatment, and how do other project variables correlate with overall progress of the client in treatment?
- Did clinician characteristics affect client outcomes? How?
- What correlations were there between client characteristics and treatment effectiveness?
- Were clients satisfied with the treatment they received?
- Were other local health care professionals aware of the program and how it works?
- What was the per unit cost of treatment?

Primary project variables are (1) client characteristics, including demographics, substance abuse history and treatment history, family and living conditions, level of education, employment and income, high-risk behaviors, criminal justice status, mental and physical health problems; (2) clinician characteristics, such as level of experience and therapeutic approach; (3) program variables, such as number of admissions, average length of stay, and types of services received; (4) cost data; and (5) data showing the perspectives of other area health care professionals regarding the proposed program. (pages15–16)

Instruments and Data Management—The project discusses the use of the following instruments:

- CSAT Government Performance Results Act (of 1993) (GPRA)
- Service Delivery Unit (SDU) Instrument (CSAT, 1999)
- Clinician Background and Practice Instrument (CSAT, 1999)
- Client Data—Adult (CSAT, 1999)
- Record Abstraction Form (CSAT, 1999)
- Brief Symptom Inventory (BSI)
- Drinking Problems Index (DPI)
- Counselor Effectiveness Rating Scale (CERS)
- Uniform Accounting System and Cost Reporting for Substance Abuse Treatment Providers (Caliber, 1998)
- D. Bruce Mansfield Center individual assessment
- Mini-Mental State Examination (MMSE)

In addition, the project will administer an anonymous client satisfaction survey and a community impact survey (administered to a random selection of local social and medical service providers). Project data will also be extracted from clinicians' notes and client medical records. (pages 15–19; Appendix 6, pages 93–220)

GPRA data will be collected and reported in accordance with CSAT requirements. Trends and patterns of service utilization for all clients will be documented via computer entry on a monthly basis, and a corresponding monthly statistical report will be prepared. These reports and others will be reviewed by the project director and, where appropriate or necessary, discussed with treatment staff. Quarterly reports

will be completed as required by CSAT, and an annual report will be produced for the ADM board and board of trustees for Mature Services, Inc. In addition, the project's advisory committee will be supplied with reports on program activities and process and service outcomes. (pages 17–18, 20, 25)